CALIFORNIA STATE ATHLETIC COMMISSION

Offices: 1424 HOWE AVENUE, SUITE 33, SACRAMENTO, CA 95825-3217 (916) 263-2195 FAX (916) 263-2197
5757 W. CENTURY BLVD., GF-16, LOS ANGELES, CA 90045 (310) 641-8668 FAX (310) 641-8516

MEDICAL INSURANCE COVERAGE CERTIFICATION

CALIFORNIA STATE ATHLETIC COMMISSION REQUIREMENTS AND CONDITIONS OF ACCEPTABLE MEDICAL INSURANCE COVERAGE:

The California State Athletic Commission requires all California promoters of professional and amateur boxing, kickboxing, and martial arts to possess medical insurance for boxers, kickboxers, and martial arts fighters who participate in contests on their shows.

All insurance policies must be from a company approved by the California State Department of Insurance and the California State Athletic Commission.

The minimum coverage required by the commission is as follows:

$20,000 MEDICAL $100 DEDUCTIBLE

It is the promoter's responsibility for the payment of the deductible portion of the policy.

The promoter must provide a $20,000 short-term medical insurance program, approved by the commission, prior to an event. The policy must be secured 48 hours prior to the scheduled event and must be notified by the insurance company providing coverage.

Section I: To be completed by promoter (please print or type).

1. NAME OF PROMOTER(S): _____

2. DOING BUSINESS AS: _____
(Name of Club)

3. INSURANCE COMPANY: _____

4. NAME OF INSURANCE AGENT/BROKER: _____

_____ _____
Promoter Signature Date

HAVE INSURANCE AGENT/BROKER COMPLETE SECTION II FOR INSURANCE CERTIFICATION.

State of California Department of Consumer Affairs

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SECTION II

MEDICAL INSURANCE COVERAGE CERTIFICATION

Section II. To be completed by the Insurance Agent/Broker (Please print or type).

1. INSURANCE AGENT/BROKER: _____

2. BUSINESS ADDRESS: _____
(Street)
_____
(City) (State) (Zip)

3. PHONE NUMBER: (_____) _____

4. INSURANCE COMPANY: _____

5. ADDRESS: _____
(Street)
_____
(City) (State) (Zip)

6. POLICY NUMBER: _____
COMMENCING DATE: _____ EXPIRATION DATE: _____

7. COVERAGE – MEDICAL: _____
OTHER: _____

ANY ADDITIONAL INFORMATION OR CONDITIONS: _____

_____

_____

_____ _____
BROKER/AGENT SIGNATURE DATE

PLEASE FORWARD COMPLETED MEDICAL CERTIFICATION FORM TO THE ATHLETIC COMMISSION